

## Important Summer Camp Information

Please read the following information to help make your child's camp adventure a success: This form does not have to be returned.

- Summer Camp will be at Ellen T Briggs (Lake Hopatcong). If you need directions, please call the office at 663-2704.
- Camp will open at 7:00 a.m. and close at 6:00 p.m.
- All children must be at the school by 9:00 a.m.
- Please advise the Center of any special needs that your child may have (i.e. asthma, Summer School, Bee Sting allergies, etc.)
- Individual medication forms will be available on the first day of camp to those parents whose children require medications on a daily basis.
- **All Universal Health forms and immunization records must be returned before your child can start camp.**
- The first day of camp- Wednesday June 26th
- The last day of camp -Friday, August 23rd
- Please send your child everyday with a bathing suit, towel and a lunch clearly marked with their names. **For safety reasons children must wear sneakers. No sandals please!**
- Tee shirts will be given out on the first day of camp. **Children must wear camp Tee-shirts on day of trip.** (Those children who are not wearing a Camp Tee Shirt will not be permitted to attend!!)
- Send a spare change of clothes with your child's name clearly marked on each item.

Thank you in advance for your cooperation. We are looking forward to having a happy and safe summer.

Summer Camp 2024  
Registration Checklist

- Fee Agreement  
Complete both sides and return to Center.
  - Universal Health Record  
Must be turned in before Child starts camp  
Complete section I before sending to child's physician  
**Please have physician attach immunization records. Children cannot start camp without a physical**
- Note: Last physical must be after July 1, 2023**
- Permission Slip  
Complete and return to Center.
  - Emergency Form  
Complete entire form. The signatures of those individuals you are authorizing to pick up your child are not required at this time. The first time they pick up your child, they will be required to show identification and their signature will be obtained.
  - Medical Release  
Complete entire form and return to center.
  - Receipt of Information Statement  
Complete entire form and return to center.
  - Payment  
**Send 2 weeks tuition that will be held as a deposit.** This payment will be applied to your last two weeks of camp.  
Deposit due with packet, first week of tuition due on the first day of camp. To register for camp you must have a zero balance in your current program. All prior balances must be paid before your child can attend camp.



Check# \_\_\_\_\_ Cash \_\_\_\_\_ Grade \_\_\_\_\_  
Credit Card \_\_\_\_\_

**SUMMER CAMP 2024 Program Contract**

Agreement between \_\_\_\_\_ and the JEFFERSON CHILD CARE AND  
(Parent or Guardian)  
EDUCATION CENTER for the provision of service to \_\_\_\_\_  
(Child's Name/Date of Birth)

Weekly tuition includes tee shirt, activities and trips.

Check One: 2 days \$100 (T/Th) \_\_\_\_\_ 3 days \$150 (M/W/F) \_\_\_\_\_ 5 days \$250 (M-F) \_\_\_\_\_

Newly enrolled families registration fee \$40 \_\_\_\_\_

Tuition assistance may be available to eligible families.

I agree to pay a fee of \$ \_\_\_\_\_ for each week that my child is enrolled. I agree to pay two weeks tuition in advance that will be held for the last two weeks of camp. Fees are due one week in advance of camp services. A negative balance on any Friday may result in my child being refused admittance into the camp program on the following Monday morning. I understand that there will be no reduction in fees for Holidays and Emergency closings.

\_\_\_\_\_ initial

**Contracted weeks of service – No changes after May 1<sup>st</sup>**

**The first day of camp is Wednesday June 26, 2024**

Signature of Parent or Guardian

**Week of:**

June 26, 2024

July 1, 2024

July 8, 2024

July 15, 2024

July 22, 2024

July 29, 2024

August 5, 2024

August 12, 2024

August 19, 2024

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The last day of camp will be Friday August 23, 2024**

**CONTRACT CHANGES**

I agree to sign up for the specific weeks my child will be attending Summer Camp.

Changes in this contracted time will be accepted by the Child Care Office, ONLY, before May 1, 2024.

\_\_\_\_\_ initial

I understand that I will be required to withdraw my child from camp if after a one-week period for adjustment my child either through behavior, attitude or verbalization is constantly disruptive to the children, staff or Camp Program.

\_\_\_\_\_ Initial

**RIGHT TO APPEAL**

I understand that I have the right to appeal directly to the Jefferson Child Care and Education Board of Trustees if I disagree with any of the provisions within this contract and the policies as outlined in the Parent Handbook.

\_\_\_\_\_  
Initial

**LATE PICK UP FEE**

In addition to the assessed fee, I agree to pay a late charge of \$1.00 per minute. Hours of operation are 7am - 6:00pm. I understand that my child will not be readmitted to the Center if the late fee is not paid within one week.

\_\_\_\_\_  
Initial

Address of Child:

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Home Phone

Parent's place of Business:

Mother \_\_\_\_\_  
Name

\_\_\_\_\_  
Company Work # cell #

Father \_\_\_\_\_  
Name

\_\_\_\_\_  
Company Work # cell #

**Tee Shirt Size**

Child Size: 10-12 \_\_\_ 14-16 \_\_\_ Youth Small: 7-8 \_\_\_  
Adult: S \_\_\_ M \_\_\_ L \_\_\_ XL \_\_\_

\_\_\_\_\_  
Parent Signature or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Center Representative Signature

\_\_\_\_\_  
Date

**EMERGENCY FORM**

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
                    Last                      First                      Middle

Address of child \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Child Living With: Both Parents \_\_\_\_ Mother Only \_\_\_\_ Father Only \_\_\_\_ Other \_\_\_\_

(Drop-off or Pick -up restrictions/court orders require Legal Documents)

Mother  
Name

Father  
Name

Address

Address

Phone

Phone

Cell#

Cell#

E-Mail:

E-Mail:

Place of Business or School

Name

Name

Address

Address

Phone

Hrs.

Phone

Hrs.

Physician

Name \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

Insurance Co./# \_\_\_\_\_

**Emergency & Sign Out Names** (please print name, signature not required at this time.)

Emergency contacts (an adult that must be available within 30 minutes of calling in case of parent or guardian unavailability)

1. Name  
Address  
Signature  
Phone

2. Name  
Address  
Signature  
Phone

3. Name  
Address  
Signature  
Phone

4. Name  
Address  
Signature  
Phone

Note here any medical problem or allergy \_\_\_\_\_

I give my permission to Jefferson Childcare & Education Center for the following:

1. To give medical treatment to my child if necessary.
2. For my child to be photographed, taped or filmed and use his./her work for display and publication.

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_



I (We) \_\_\_\_\_  
Name(s)

Of \_\_\_\_\_ do hereby state \_\_\_\_\_  
City County State

That I am (we are) the parents/guardians, having legal custody of \_\_\_\_\_

Child's Name \_\_\_\_\_  
A minor, age \_\_\_\_\_, born \_\_\_\_\_ who resides with me (us) at \_\_\_\_\_  
Address

I (We) authorize Jefferson Child Care and Education Center, P.O. Box 527: 29 Nolan's Point Rd., Lake Hopatcong, NJ 07849, to consent to an X-Ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general supervision of a licensed Physician or Surgeon.

Dated this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent (s) or Guardian (s)

Witness \_\_\_\_\_ Date \_\_\_\_\_

Existing medical problems of child, in any \_\_\_\_\_

Existing allergies, if any \_\_\_\_\_

Child's Doctor \_\_\_\_\_ Doctor's phone # \_\_\_\_\_

Specialist \_\_\_\_\_ Parent's Doctor \_\_\_\_\_

Medications that child is taking \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group \_\_\_\_\_

\*\* Please attach a copy of your child's medical insurance card \*\*

Identification # \_\_\_\_\_ Last tetanus shot \_\_\_\_\_

Provided as a Public Service by  
Northwest Covenant Medical Center  
Sponsored by the Sisters of Sorrowful Mother

Department of Emergency Medicine:  
Dover General Campus, Dover .... 973-989-3200  
St. Clare's, Denville ..... 973-625-6063

# UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter  
New Jersey Academy of Family Physicians  
New Jersey Department of Health

## SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last) _____ (First) _____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Child's Health Insurance Carrier _____		
Parent/Guardian Name _____	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
Parent/Guardian Name _____	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
<b>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</b>			
Signature/Date _____		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

## SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: _____	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormalities Noted: _____	Weight (must be taken within 30 days for WIC)
	Height (must be taken within 30 days for WIC)
	Head Circumference (if <2 Years)
	Blood Pressure (if ≥3 Years)

### IMMUNIZATIONS

- Immunization Record Attached  
 Date Next Immunization Due: \_\_\_\_\_

### MEDICAL CONDITIONS

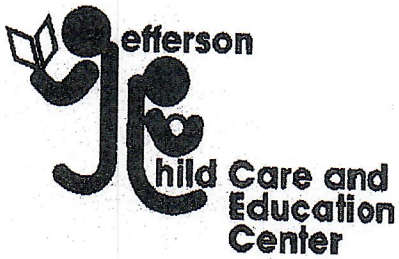
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments

### PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print) _____	Health Care Provider Stamp: _____
Signature/Date _____	



## RECEIPT OF INFORMATION STATEMENT

I hereby certify that I have received and read a copy of the Jefferson Child Care and Education Center Parent's Manual which includes the information to parent's statement, as published by the Office of Licensing, Child Care & Youth Residential Licensing, in the Department of Children And Families in addition to the Center policies below:

- Information to Parents Document
- Policy on the Release of Children
- Policy on Dispensing Medication
- Policy on Methods of Parental Notification
- Positive Guidance and Discipline Policy
- Policy on Management of Communicable Diseases
- Expulsion from program
- Policy on the Use of Technology and Social Media

Child's Name \_\_\_\_\_

Parent's Name \_\_\_\_\_

Date \_\_\_\_\_

My child \_\_\_\_\_ is in good health and can participate in the normal activities of the program.

Please list below any conditions or special needs that may require special accommodations for your child.

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\_\_\_\_\_  
Signature of Parent or Guardian